Standard Health Insurance Contract (SHIC)
APPLICATION & CHANGE OF CIRCUMSTANCES FORM

1. Please complete ALL required sections/questions on this document in block letters and indicate "N/A" where not applicable.
2. Include copies of all the specified & relevant documents.

ALL INFORMATION CONTAINED ON THIS FORM IS CONFIDENTIAL

CINICO USE ONLY (FILL-IN & TICK)

Group No: 31304
Member #: 99_ - _ _ - _ _ _ _
☐ **New** ☐ **Reinstate** ☐ **Add**
☐ **Change** ☐ **Terminate Policy**
Effective Date: dd / mm / yyyy
CSM: OE DL DE JD

☐ **TERMINATE POLICY**	☐ AFFORDABLE	☐ SILVER(Individual Only)	☐ GROUP	☐ TEMPORARY(Employer Only)

SECTION A - APPLICANT INFORMATION:

1. Last Name: | First Name: | Middle Name:

2. Physical Address: | District: | P.O. Box #: | Postal Code: KY__ -__ __ __ __

3. Gender: ☐ Male ☐ Female	**4.** Birth Date: dd / mm / yyyy	**5**. Email Address:	**6.** Height: Feet / Inches	**7.** Weight: Lbs. / Oz.
8. Home Telephone:	**9.** Cell Phone:	**10.** Employment Status: ☐ Employed ☐ Self-Employed	☐ Unemployed ☐ Retired **(Section B – N/A)**	

11. Please check the level of coverage you desire:
☐ Single ☐ Family (Single + Spouse + Child(ren)
☐ Single + Dependent Child(ren) ☐ Couple (Single + Spouse)

12. Immigration Status & Nationality: ☐ Caymanian/Status Holder
☐ Work Permit Holder ☐ Permanent Resident
☐ Other: _____ Nationality: _____
Passport #: _____

13. Beneficiary Name: | **14.** Relationship: | **15.** Date of Birth: dd / mm / yyyy

SECTION B - EMPLOYER INFORMATION:

1. Name of Employer/Company: | 2. Company Authorized Representative: | 3. Employer #:

4. Physical Address: | 5. Postal Address: | 6. Email Address:

7. Telephone Number: | 8. Fax Number:

In accordance with Sect. 7. of the Health Insurance Law (2016), I acknowledge that I am liable to pay the premium with respect of this policy.
8. Employer's Authorized Representative signature: | **9. Date:** dd / mm / yyyy

SECTION C – ELIGIBLE DEPENDENTS INFORMATION: (not applicable for Silver or Temporary Plans)

2 Notes: A. Non-Resident Dependents are not eligible for coverage. B. *Child(ren) includes Dependent Offspring (DO).

16. Full Name of Spouse and/or Child(ren): (Passport (or an Affidavit of Nationality) + Applicable Documentation i.e. Marriage Certificate, Birth Certificate and Photographic Identification of all Eligible Dependents)	**17.** Gender (M/F)	**18.** Birth Date:	**19.** Relationship (Spouse or Child*)	19a. Height Feet / Inches	19b. Weight Lbs. / Oz.	**19c.** Immigration Status
1.		dd / mm / yyyy	Spouse			
2.		dd / mm / yyyy	Child or DO			
3.		dd / mm / yyyy	Child or DO			
4.		dd / mm / yyyy	Child or DO			

20. Are Medical benefits available from any other approved Insurer to any person listed above? ☐ No ☐ Yes
If Yes, Please State Name of Approved Insurer & Telephone #:
Approved Insurer: **Telephone #:**

21. Is your Spouse employed? ☐ No ☐ Yes | If Yes, Please State Name of your Spouse Employer & Telephone#:

22. Has any person listed above had continuous coverage for a period of not less than 1 year?
☐ No ☐ Yes. If Yes, please provide name of the approved Insurer & Phone #:

SECTION D – MEDICAL QUESTIONNAIRE:

In the last 12 months has the Applicant or any Eligible Dependent listed above ever been advised to, or received medical consultation, care, treatment or taken medication in relation to any of the following:

1. Heart or circulatory system (including but not limited to infarction, heart attack, angina, rheumatic fever, cardiac defect, arrhythmias, diseases of veins, arteries or valves, stroke) and/or any other symptom regarding circulatory system or heart.	**NO / YES (IF YES, Please identify)** ☐ ☐ Name(s) _____
2. Sexually transmitted diseases or Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) or ARC (AIDS related complex).	**NO / YES (IF YES, Please identify)** ☐ ☐ Name(s) _____

3. Neurological System (including but not limited to convulsions Epilepsy, Paralysis, Multiple Sclerosis, Cerebral Infarction (stroke), Alzheimer's disease, Dementia) and/or any other symptom regarding the neurological system, which if referred to a doctor would result in a diagnosis.	**NO / YES (IF YES, Please identify)** ☐ ☐ Name(s) _____
4. Liver disorders (including but not limited to fatty liver, cirrhosis, hepatitis) and/or any other symptom regarding the liver, which if referred to a doctor would result in a diagnosis.	**NO / YES (IF YES, Please identify)** ☐ ☐ Name(s) _____
5. Kidney/Renal disease or failure?	**NO / YES (IF YES, Please identify)** ☐ ☐ Name(s) _____

SECTION D – MEDICAL QUESTIONNAIRE continued:

In the last twelve (12) months has the Applicant or any Eligible Dependent listed ever:

6. Been treated for Cancer?	**NO / YES (IF YES, Please identify who and specify what)** ☐ ☐ Who: What:
7. Been treated for Diabetes (sugar)?	**NO / YES (IF YES, Please identify who and specify what)** ☐ ☐ Who: What:
8. Been treated for Hypertension (High Blood Pressure)?	**NO / YES (IF YES, Please identify who and specify what)** ☐ ☐ Who: What:
9. Been treated for Respiratory conditions? (Emphysema, Bronchitis, Pneumonia, Asthma, Cystic fibrosis etc.)	**NO / YES (IF YES, Please identify who and specify what)** ☐ ☐ Who: What:
10. Had an Organ Transplant.	**NO / YES (IF YES, Please identify who and specify what)** ☐ ☐ Who: What:
11. Had Major Surgery? (Any surgery in which you were put under general anesthesia and given respiratory assistance).	**NO / YES (IF YES, Please identify who and specify what)** ☐ ☐ Who: What:
12. Are you, or any of the Eligible Dependents, currently on medications and/or sustained an injury or any sickness (not listed in Sect. D Q. 1-11 above), the signs of which first appeared on or before the date of this application?	**NO / YES (IF YES, Please identify who and specify what)** ☐ ☐ Who: What: Who: What: Who: What: Who: What:
13. Females Only: **Are you Pregnant?**	**NO / YES (IF YES, Please identify who and the number of weeks gestation)** ☐ ☐ Who: Weeks: Who: Weeks:

Has any approved insurer within the last twelve months:

14. Declined a Health Insurance application for you, or any Eligible Dependent listed.	**NO / YES (IF YES, Please specify who and explain why)** ☐ ☐ Who: Explanation: Who: Explanation:
15. Required an increased premium or imposed special conditions on you, or any Eligible Dependent listed.	**NO / YES (IF YES, Please specify who and explain why)** ☐ ☐ Who: Explanation: Who: Explanation:
16. Cancelled or refused to renew an existing health insurance policy for you, or any Eligible Dependent listed.	**NO / YES (IF YES, Please specify who and explain why)** ☐ ☐ Who: Explanation: Who: Explanation:

Declaration

I hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true as at this date. I hereby authorize any registered medical practitioner, healthcare facility or approved insurer which has copies of my health records to release such information to CINICO. A photocopy of this signed authorization shall be as valid as the original. I understand and agree that any injury that occurred within twelve months before the date of this application or any sickness, the signs of which first appeared on or before the date of this application, are not covered by this contract unless fully disclosed on this application. Failure to disclose such information could result in denial of a claim and the cancellation of coverage. I understand and agree that coverage shall not become effective until accepted by CINICO. I understand that any changes in my health status after submission of application and prior to approval of coverage must be reported to CINICO. I hereby declare that I have read and understand the "Policy Rules and Eligibility Conditions" applicable to this Insurance policy.

Signature of Applicant: _____ **Signature of Eligible Dependent (18 years or older): _____**

Date: d d / m m / y y y y **Signature of Eligible Dependent (18 years or older): _____**

THIS APPLICATION WILL BE VALID FOR 30 DAYS FROM THE DATE OF SIGNATURE
FAILURE TO DISCLOSE RELEVANT DETAILS OR GIVING MISLEADING INFORMATION ON THIS FORM MAY CAUSE YOUR APPLICATION AS WELL AS YOUR INSURANCE COVERAGE TO BE DEEMED NULL AND VOID.

POLICY RULES & ELIGIBILITY CONDITIONS

General Information and Requirements for all Applicants & Participants

1. The Policy, which includes this **"Policy Rules & Eligibility Conditions"** document, the "**SHIC Application & Change of Circumstance Form (SHIC App. Form)** ", and any amendment agreed to in writing, may not be changed, or any provisions waived unless agreed to in writing by the CEO or CFO of CINICO.
2. All New Applicants, and Existing Members, must complete a new "**SHIC Application & Change of Circumstance Form**" each time there is a change in any component of the information contained in Section A, B & C.
3. Premiums are subject to increase with a minimum of 30 Days' notice.
4. Premiums are payable monthly in advance, and are due on, or before, the **1st day of every month**.
5. In accordance with Section 7 of the Health Insurance Law (2016 Revision) the employer shall be liable to pay the premium payments.
6. Premium payments can be made directly to CINICO or at any of the following Banks.
   -Please ensure you reference your Member Number (999-xx-1234) during all Premium Payments

Functionality	Bank of Butterfield	RBC	CNB
Payee (On-Line)	Yes	Yes	Yes
Walk-in Teller Deposit	Not at this time	Not at this time	Yes
Monthly Direct Debit Deposit	Yes	Yes	Yes

7. A policy is automatically terminated, for non-payment of premium, within 30 days of the due date.
8. All Post-Termination/Cancellation premium payments will be refunded to the Employer designated on the **"SHIC App. Form"**. If self-employed, unemployed or retired, these refunds will be remitted to the primary policy holder.
9. A **"SHIC App. Form"** must be completed for any changes in coverage including Policy Termination AND this document and/or notice, including post-marked envelopes, **must** be received by CINICO by the 15th day of the month and becomes effective the 1st day of the following month.
   a. CINICO is **not responsible for the refund of any Premiums** collected for any period in which an insured member had a change of circumstance, whereby their premium obligations would have changed prior to this notification.
10. A terminated policy can **ONLY** be reactivated under **BOTH** of the following conditions:
    a. A new "**SHIC App. Form**" must be completed along with any required information, **AND**
    b. A reinstatement fee must be paid in the amount of CI$200.00 for the first reactivation and CI$300.00 for every subsequent occurrence.
11. The currency of the Policy and any quoted Premiums is Cayman Islands Dollars.
12. This policy is only available to Legal Residents of the Cayman Islands.
13. Failure to disclose relevant details or giving misleading information on any formal communication to CINICO may cause your application as well as your Insurance coverage to be deemed null and void.

'Affordable' Plan Participation

1. Participation is available to residents of the Cayman Islands who are under 65 years of age.
2. Legal Resident Spouses, Children & Dependent Offspring may enroll in this plan.

'Silver' Plan Participation

1. Participation is only available to individual residents of the Cayman Islands who are aged 65 or older.
2. Children & Dependent Offspring may not enroll in this plan.

CAYMAN ISLANDS CINICO NATIONAL INSURANCE COMPANY "Good Risk Should Be Insured"

RISK RATING PROCESS & ENROLLMENT INFORMATION REQUIREMENTS

RISK RATING PROCESS

As the New Law now permits individual "Risk Ratings", and prohibits the refusal of coverage, each Applicant (and Participant) is subject to an individual risk score that is used to determine their total premium. An Applicants Height & Weight (Questions 19a &19b of Section C) along with any "Yes" answers to questions 1 - 16 of Section D of the "SHIC Application & Change of Circumstance Form" are used to apply a predetermine risk score. This score is then added to the base rates* approved by the Department of Health & Regulatory Services. (See "Risk Rating Example" below)

*** Department of Health Regulatory Services - Approved Premium Rates**

"Affordable" Plan Band	Age Range	Base Amount CI$
A	Dependent Child	$ 69.00
B	18-39	$ 124.00
C	40-44	$ 138.00
D	45-49	$ 160.00
E	50-59	$ 167.00
"Silver" Plan Band	60+	$ 300.00

Risk Rating Example

29 y/o Applicant
- Base Rate of $124.00
Q.19 a&b: BMI Score: 32.1
= Risk Score of .30
Q.8: Yes (Hypertension)
Q.12: No Medications
Conclude: "Uncontrolled"
= Risk Score of .50

Risk Rating Formula

Base Rate x Risk Rating Score
Total Risk Score = .80
$124.00 x (1+.80) = **$223.20**

ENROLLMENT INFORMATION REQUIREMENTS

✓ **All applicants must provide:**

	1. A fully completed "SHIC Application & Change of Circumstance Form".
	2. A Valid Photo ID: Passport, Voter's Registration Card, or Driver's License (Per Applicant and Dependent).
	3. Proof of Dependent(s) relationship: Marriage Certificate, Birth Certificate, Adoption Certificate, etc.
	4. Foreign National: Proof of a valid work permit or Permanent Residency.
	5. Verification of PO BOX for Mail: Utility Bill or Lease Agreement (or Driver's License if current)
	6. Verification of Physical Address: Utility Bill or Lease Agreement (or Driver's License if current)

Upon receipt of the required information, the application will be reviewed, risk rated and the applicant will be notified of their Risk Rating results and where applicable, what their monthly premium payments will be. At which time, the applicant is then required to make payment to CINICO to bind the policy.

CAYMAN ISLANDS CINICO NATIONAL INSURANCE COMPANY
Good Health Should Be Insured.

VERSION: June 18th, 2013-LTibbetts

The SHIC (2013) Plan became effective March 1st, 2013 with the Legislation of the Health Insurance (Amendment) Regulations 2012.

SHIC (2013) Plan Details

Description	SHIC (2013) - Affordable or Silver Plan
MAXIMUM LIFETIME BENEFIT AMOUNT	$1,000,000 Cayman Islands Dollars
MAXIMUM CALENDAR YEAR	$100,000 Cayman Islands Dollars
MAXIMUM PER MEDICAL INCIDENT	not applicable
COINSURANCE	20% up to the first $5,000
DEDUCTIBLE	None
OUT-OF-POCKET (OOP)	$1,000 Max. OOP after which CINICO will pay all Inpatient and Ambulatory benefits up to the maximum.

COVERED CHARGES

All covered expenses are paid in accordance to the S.H.I.F. schedule or a CINICO negotiated rate.

Emergency Medical Services (inclusive of emergent medication, drugs, and ambulance)	100% up to $4,000 per policy year
Air Ambulance **Air Ambulance for "life or limb" threatening emergency** **Medical Airfare for "life or limb"**	100% up to $15,000 per Policy Year
Prescription Drugs: Including contraceptives and contraceptive devices available by prescription only & Insulin.	* 80% up to $400 (CIHSA, Local Providers and Overseas Providers with Chief Medical Officer - CMO approval)
Doctors Office Visits and other Physician fees including office procedures. Diagnostics including Radiological/Labotory, Physio Therapy with physician (CMO) referral only.	
Wellness Benefits Routine Physicals, Annual Exams, Wellness Services, Well child care, Nutrition counselling with physician (Referral required),One Dental examination/check up and prophhylaxis annually.	80% within the $200 policy year maximum for wellness services
In-patient Hospital Care (Including Physician, Specialist, Surgical services, Medications & Drugs, [Nursing care, Accomodation & meals in a semi-private room max of 30 days]) **Out-Patient Surgery in an Ambulatory Surgical Center or Hospital** **Chemotherapy or Radiation Therapy (in-patient or out-patient)** **Maternity-labour and delivery, major maternity procedure and hospitalization** **Post-Natal (Newborn Care) 1st 30 Days**	80% to coinsurance maximum, then 100% to Individual Annual Maximum ($100,000)
Haemodialysis	100% to $100,000 per year
Mental Health-Inpatient Benefits	** 80% to coinsurance maximum, then 100% up to $25,000 per Lifetime
Maternity Care **(A) Pre-Natal Care** **(B) Post-Natal Care** **(C) Delivery**	(A) Pre-Natal Care – 80% within the $500 per pregnancy benefit (B) & (C) Delivery and Post-Natal Care Covered under Inpatient Benefits
Repatriation of Remains	$2,000

IMPORTANT CONDITIONS & NOTES OF COVERAGE

*CINICO is responsible for 80% of approved services up to the $400 ($320) Member responsible for $80

** Mental Health is a covered In-patient benefit with a 80% Coinsurance maximum, then 100% up to $25,000 per lifetime.

A. Emergency means a sudden or unexpected occurrence or event causing a threat to life or limb.

B. All Non-CIHSA emergency admissions must be certified by contacting CINICO within 48 hours from the date of service.

C. IN NETWORK: Cayman Islands Health Services Authority (CIHSA) OR LOCAL & OVERSEAS PROVIDERS, **WITH** Chief Medical Officer (CMO) approval, will be covered where medically necessary in accordance with the benefit plan.

D. OUT OF NETWORK: Any LOCAL and/or OVERSEAS Care, **WITHOUT** CMO approval will NOT be covered under any plan.